No. 300
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34565

FILED OCT 23 1948
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8890

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Barnes Hospital,
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 months & 20 days (Specify whether)

In this community (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ST. LOUIS

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5435 Maple
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Angelo G. Phillips

3. (b) If veteran, name war No

3. (c) Social Security No. 498-01-3425

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased ? (Month) ? (Day) 1904 (Year)

8. AGE: Years 44 Months ? Days ? If less than one day hr. min.

9. Birthplace Koritza (City, town, or county) Albania (State or foreign country)

10. Usual occupation Waiter

11. Industry or business

FATHER
12. Name Alepios Gikathia
13. Birthplace Koritza (City, town, or county) Albania (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Koritza (City, town, or county) Albania (State or foreign country)

16. (a) Informant A.D. Pappas
(b) Address 5435 Maple Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-48 (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cemetery

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) OCT 13 1948 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 12
year 1948 hour 3 minute 53 P.M.

21. I hereby certify that I attended the deceased from January 22, 1948, to October 12, 1948
that I last saw him alive on October 12, 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uremia	3 weeks
Due to: Hypertensive cardiovascular disease and malignant nephrosclerosis	3 + mo.
Due to	
Other conditions (Include pregnancy within 3 months of death): TERMINAL BRONCHO*PNEUMONIA	1 day

PHYSICIAN

Major findings:
Of operations
Of autopsy AS ABOVE

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature James H. Owen (M. D. or other)
Address Barnes Hospital, Date signed 10-12-48

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by .....

....., Registered Apprentice No. .....

working under my personal supervision.

Signed Gustav W Dietrich

Licensed Embalmer No. 4329

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.